

4693

04693

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <i>Bel Air</i>	LENGTH OF STAY (in this place) <i>4 years</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Bel Air</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Toll Gate Road</i>		STREET ADDRESS (If rural, give location) <i>Toll Gate Road</i>	
3. NAME OF DECEASED: (Type or Print) <i>SIDONIA CHAMBERS ANDERSON</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>23</i> (Year) <i>1955</i>	
5. SEX: <i>FEMALE</i>	6. COLOR OR RACE: <i>NEGRO</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>WIDOWED</i>	8. DATE OF BIRTH: <i>MAY 3, 1872</i>
9. AGE last birthday <i>83</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>JOHN WESLEY CHAMBERS</i>		14. MOTHER'S M maiden NAME: <i>ALICE COLLINS</i>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.: _____	
17. INFORMANT & ADDRESS: <i>ALICE A. CHAMBERS, Bel Air, Md</i>		RD # <i>2</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause <i>443x</i>	(a) <i>Cerebral vascular accident</i>	<i>4 days</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) <i>Hypertension Cardio Vascular Disease with arteriosclerosis</i>	<i>over 4 years</i>
(c)		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture rt hip 1951; Hipster Fracture 1954</i>	
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19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE <i>Philip W. Newman</i>	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	DATE SIGNED <i>May 23, 1955</i>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removal</i>	DATE THEREOF <i>May 27, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Clarks Chapel</i>
LOCATION (City, town, or county) (State) <i>Bel Air, Md.</i>	24. FUNERAL DIRECTOR <i>Funeral Home</i>	ADDRESS <i>1631 South Hill Ave.</i>
DATE REC'D BY LOCAL REG. <i>5-2x-55</i>	REGISTRAR'S SIGNATURE <i>A. W. Hedrick</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



04694

182

4711

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Bel Air</u>		<u>1yr.9mo.</u>		TOWN <u>Taneytown</u>		<u>06X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>90 Convalescent Home</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rose</u> (Middle) <u>May</u> (Last) <u>Bailey</u>				(Month) <u>May</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 15, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Taneytown-Carroll Co., Md.</u>		<u>America</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George W. Demmit</u>				<u>Elizabeth Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>218-01-5137</u>		<u>Russell R. Crebs</u> <u>502 S. Shippen St., Lancaster, Pa.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>Sudden death</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-vascular Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 6, 1953</u> to <u>May 23, 1955</u> , that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hedgcock</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>5-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/26/55</u>		<u>Reformed Cemetery</u>		<u>Taneytown, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 25, 1955</u>		<u>Ethel M. Mchling</u>		<u>Merwyn C. Fues</u>		<u>Taneytown, Maryland</u>	
		<u>Marilla Towood Local</u>					

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2007 JUNE 20

RECEIVED
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20461
MAY 31 1965

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF JAILER

19. SIGNATURE OF WARDEN

BUREAU V. S.

MAY 31 1965

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4694

CERTIFICATE OF DEATH

04695

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MD Route 7, Harre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Alice R Bateman</u>				4. DATE OF DEATH <u>May 4 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>6/22/1919</u>	
9. AGE last birthday <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler, shoe mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Racey</u>				14. MOTHER'S MAIDEN NAME <u>Martha J. Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216 34 5219</u>		17. INFORMANT & ADDRESS	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
812X IMMEDIATE CAUSE (A) <u>Fracture Cervical Vertebra</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Compound Fracture Both Bones R Leg</u>						2 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>MD Route 7</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Harre de Grace</u> (County) <u>Harford</u> (State) <u>MD.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) <u>May 3 1955 958P</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident, antipedeestrian type</u>			
22. I hereby certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Gerald E. Palmer</u>				M.D. <u>Deputy Medical Examiner</u>		DATE SIGNED <u>5/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>5/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Georges</u>		LOCATION (City, town, or county) <u>Harford Md.</u> (State)	
24. REC'D BY REGISTRAR <u>May 6 - 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u>		ADDRESS <u>Harford Md.</u>	

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4695

04696

CERTIFICATE OF DEATH

Reg. Dist. No. 183-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford Maryland</i>	CITY OR TOWN <i>Harford</i>	CITY OR TOWN <i>Harford</i>	CITY OR TOWN <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	CITY (If outside corporate limits, write RURAL and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS	HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS
3. NAME OF DECEASED		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<i>Erica D. Beckman</i>		<i>3/4/55</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>2/2/1881</i>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>74</i>	<i>None</i>	<i>Harford, Md.</i>	<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Thomas Mackin</i>		<i>Margaret Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>None</i>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<i>Mr Donald Magler, 525 P. Washington, Harford, Md.</i>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		19a. DATE OF OPERATION	
		<i>11/1/54</i>	
		19b. MAJOR FINDINGS OF OPERATION	
		<i>Breast, Carcinoma</i>	
		20. AUTOPSY?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or injury street, office bldg., etc.)	
<input type="checkbox"/>		<i>Home</i>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
<i>Harford, Md.</i>		<i>3/4/55</i>	
21e. HOW DID INJURY OCCUR?		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<i>None</i>		<i>None</i>	
22. I hereby certify that I attended the deceased from <i>2/10, 1957</i>, to <i>3/4, 1955</i> that I last saw the deceased alive on <i>3/4, 1955</i>, and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city or town, state)	
<i>Charles J. Fley, M.D.</i>		<i>Harford, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR	
<i>Burial</i>		<i>5/7/55</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	
<i>Harford, Md.</i>		<i>Harford, Md.</i>	
DATE		DATE	
<i>May 6-1955</i>		<i>May 6-1955</i>	

CERTIFICATE OF DEATH

Form No. 10-1-55

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. PLACE OF DEATH (Print or Write)

10. DATE OF DEATH (Month, Day, Year)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF REGISTRAR (Print or Write)

13. SIGNATURE OF WITNESS (Print or Write)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF NEXT OF KIN (Print or Write)

16. SIGNATURE OF CLERK (Print or Write)

17. SIGNATURE OF CHURCH CLERK (Print or Write)

18. SIGNATURE OF MINISTER (Print or Write)

19. SIGNATURE OF RABBI (Print or Write)

20. SIGNATURE OF OTHER (Print or Write)

21. SIGNATURE OF OTHER (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

23. SIGNATURE OF OTHER (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

26. SIGNATURE OF OTHER (Print or Write)

27. SIGNATURE OF OTHER (Print or Write)

28. SIGNATURE OF OTHER (Print or Write)

29. SIGNATURE OF OTHER (Print or Write)

3. NAME OF DECEASED (Print or Write)

4. SEX (Male or Female)

5. AGE (Years and Months)

6. DATE OF BIRTH (Month, Day, Year)

7. PLACE OF BIRTH (City, State, Country)

8. OCCUPATION (Print or Write)

9. CAUSE OF DEATH (Print or Write)

10. MANNER OF DEATH (Print or Write)

11. PLACE OF DEATH (Print or Write)

12. DATE OF DEATH (Month, Day, Year)

13. SIGNATURE OF PHYSICIAN (Print or Write)

14. SIGNATURE OF REGISTRAR (Print or Write)

15. SIGNATURE OF WITNESS (Print or Write)

16. SIGNATURE OF DECEASED (Print or Write)

17. SIGNATURE OF NEXT OF KIN (Print or Write)

18. SIGNATURE OF CLERK (Print or Write)

19. SIGNATURE OF CHURCH CLERK (Print or Write)

20. SIGNATURE OF MINISTER (Print or Write)

21. SIGNATURE OF RABBI (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

23. SIGNATURE OF OTHER (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

26. SIGNATURE OF OTHER (Print or Write)

27. SIGNATURE OF OTHER (Print or Write)

28. SIGNATURE OF OTHER (Print or Write)

29. SIGNATURE OF OTHER (Print or Write)

30. SIGNATURE OF OTHER (Print or Write)

31. SIGNATURE OF OTHER (Print or Write)

3. NAME OF DECEASED (Print or Write)

4. SEX (Male or Female)

5. AGE (Years and Months)

6. DATE OF BIRTH (Month, Day, Year)

7. PLACE OF BIRTH (City, State, Country)

8. OCCUPATION (Print or Write)

9. CAUSE OF DEATH (Print or Write)

10. MANNER OF DEATH (Print or Write)

11. PLACE OF DEATH (Print or Write)

12. DATE OF DEATH (Month, Day, Year)

13. SIGNATURE OF PHYSICIAN (Print or Write)

14. SIGNATURE OF REGISTRAR (Print or Write)

15. SIGNATURE OF WITNESS (Print or Write)

16. SIGNATURE OF DECEASED (Print or Write)

17. SIGNATURE OF NEXT OF KIN (Print or Write)

18. SIGNATURE OF CLERK (Print or Write)

19. SIGNATURE OF CHURCH CLERK (Print or Write)

20. SIGNATURE OF MINISTER (Print or Write)

21. SIGNATURE OF RABBI (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

23. SIGNATURE OF OTHER (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

26. SIGNATURE OF OTHER (Print or Write)

27. SIGNATURE OF OTHER (Print or Write)

28. SIGNATURE OF OTHER (Print or Write)

29. SIGNATURE OF OTHER (Print or Write)

30. SIGNATURE OF OTHER (Print or Write)

31. SIGNATURE OF OTHER (Print or Write)

UREAU V. S.

8 1955

VED

4712

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i> MARYLAND				STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY OR TOWN <i>Lapidum</i> (If outside corporate limits, write RURAL and give nearest town)				CITY OR TOWN <i>Lapidum</i> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Julia</i> (Middle) <i>Gunn</i> (Last) <i>Burkins</i>				(Month) <i>5</i> (Day) <i>29</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>3/8/1872</i>	<i>83</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>House Wife</i>		<i>—</i>		<i>York Co. Pa.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James A. Sample</i>				<i>Mary A. McAfee</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>Unknown</i>		<i>Joseph A. Burkins Lapidum Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <i>Diabetes Mellitus</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Acute Myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pulmonary Aneurysm</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 29, 1955</i> , to <i>May 29, 1955</i> , that I last saw the deceased alive on <i>May 29, 1955</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley</i> M.D.				ADDRESS (Street, city, town, state) <i>Hannock Rd Md 57311</i>			
DATE <i>May 31 - 55</i>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6/1/55</i>		<i>Angel Hill</i>		<i>Harford Co., Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>May 31 - 55</i>		<i>A. L. Lewis M.D.</i>		<i>William J. Con...</i>		<i>Harford Co., Md.</i>	

INSTRUCTIONS

1
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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

5551 I NNC

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04698

Reg. Dist.

No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Virginia		COUNTY Campbell	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Abingdon		LENGTH OF STAY (in this place) instant		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Lynchburg		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) Thomas T. Cunningham Jr				4. DATE OF DEATH (Month) May , (Day) 17 , (Year) 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married	8. DATE OF BIRTH: June, 25, 1931	9. AGE last birthday: 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY: Transportation Co.,		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME: Thomas T. Cunningham				14. MOTHER'S MAIDEN NAME: Lucy Jane Reid			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 226-34-5014		17. INFORMANT & ADDRESS: W.C. Falwell, Lynchburg, Virginia.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
816X Immediate cause (a) 3rd degree burns entire body DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY 2540		21c. (City or town) (County) (State) Abingdon Harford Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 5/17/55 1A M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto accident, auto-into accident			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/17/55 M. D. ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 5/17/55		NAME OF CEMETERY OR CREMATORY J.E. Fauber F.H.		LOCATION (City, town, or county) (State) Lynchburg Campbell, Va.	
DATE REC'D BY LOCAL REG. May 20, 1955		REGISTRAR'S SIGNATURE Norma B. Moore		24. FUNERAL DIRECTOR ADDRESS Howard K. Mc Comas & Son Abingdon, Md.			

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4714 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04699
Item 18 Film G182 5-27-55 am

CERTIFICATE OF DEATH

Reg. Dist. No. 88

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY HARFORD		MARYLAND		STATE MD.		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WHITEFORD			
X TOWN WHITEFORD		18 yrs.		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				ADDRESS			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
MARY OLEVA DAY				MAY 9, 1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: July 21, 1905	9. AGE last birthday: 49 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY: —		11. BIRTHPLACE (State or foreign country): DELTA R.D., PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: AMOS FOUNDS			
14. MOTHER'S MAIDEN NAME: HENRIETTA MOORE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): 3 No			
16. SOCIAL SECURITY NO.: 162-05-9405				17. INFORMANT & ADDRESS: MRS. DORIS JONES, WHITEFORD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO Carcinomatosis							
ANTECEDENT CAUSE (S) DUE TO Primary site unknown							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: January 1965		19B. MAJOR FINDINGS OF OPERATION: Carcinomatosis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 19 55 to May 9 55 , that I last saw the deceased alive on May 9, 1955 , and that death occurred at 10 A.M. from the causes and on the date stated above.							
SIGNATURE Dorothy A. Hunt				M.D. Delta Pa		DATE SIGNED 5/11/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF May 12, 1955		NAME OF CEMETERY OR CREMATORY SLATE RIDGE		LOCATION (City, town, or county) (State) DELTA, PA.	
DATE REC'D BY LOCAL REGISTRAR 5-13-55		REGISTRAR'S SIGNATURE Wm. J. L. L. L.		24. FUNERAL DIRECTOR ADDRESS JOHN H. HARKINS, DELTA, PA.			

BUREAU V. S.

MAY 17 1955

RECEIVED

04700

4715

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Aberdeen</u>				OR TOWN <u>Baltimore 12</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital Aberdeen Proving Ground</u>				STREET ADDRESS (If rural give location) <u>505 Cedarcroft Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles Edward Nicholas DIMLING</u>				<u>May 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>September 14, 1912</u>	<u>42</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Safety Engineer</u>		<u>US Government</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Dimling</u>				<u>Catherine Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW II</u> <u>Army</u>		<u>042-01-5995</u>		<u>Mr Haines Civ Pers Br Aberdeen PG, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Infarction myocardium</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 18</u>, 19<u>55</u>, to <u>May 18</u>, 19<u>55</u>, that I last saw the deceased alive on <u>May 18</u>, 19<u>55</u>, and that death occurred at <u>9:18a</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Peter P. Mayock Jr.</u>				<u>US Army Hosp Aberdeen PG, Md</u>		<u>May 18 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/21/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 20, 1955</u>		<u>Nellie R. Perry</u>		<u>Wm. J. Tieben & Sons, Baltor</u>		<u>17</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1510

A. FULL NAME OF DECEASED

John Doe

Age 45

Sex Male

Color of Hair Brown

Color of Eyes Blue

Color of Skin Fair

Height 5' 8"

Weight 160 lbs

Marital Status Single

Place of Birth Baltimore, Md.

Education High School

Occupation Clerk

Usual Residence 123 Main St.

Date of Death May 20, 1955

Time of Death 10:30 AM

Place of Death Home

Cause of Death

Heart Disease

Myocardial Infarction

Coronary Artery Disease

Thrombosis

Embolism

Stroke

Pneumonia

Influenza

Tuberculosis

Cancer

Diabetes

Hypertension

Chronic Kidney Disease

Alcoholism

Other

BUREAU V. 2

MAY 20 1955

RECEIVED

John Doe

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04701

4696

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u> COUNTY <u>Cecil</u>		CITY (if outside corporate limits, write RURAL or and give nearest town) <u>North East</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>07X-2</u>	
CITY OR TOWN <u>Havre-De-Grace</u>		LENGTH OF STAY (in this place) <u>4 hrs.</u>		STREET ADDRESS <u>R.D.#1</u>		(If rural give location) <u>✓</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Howard</u>		(Middle) <u>Ewing</u>		(Last) <u>Ewing</u>		(Date) <u>May 11 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Gang</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Westley Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Priscella Dowing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-22-0725</u>		17. INFORMANT & ADDRESS <u>Mrs. Mattie K. Ewing</u>		<u>North East</u>	
		(If Yes, give war or dates of service)					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>526x</u> <u>Cardiac decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchitis</u>				<u>8 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1954</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>55</u> , and that death occurred at <u>3:00</u> M. from the causes and on the date stated above. SIGNATURE <u>Dr. R. G. Sanford</u> M.D. <u>Rising Sun, Md.</u> DATE SIGNED <u>5/12/55</u> (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Brick Meeting Burial Ground</u>		LOCATION (City, town, or county) <u>Calvert Md.</u>	
24. REC'D BY REGISTRAR <u>May 13-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	

CERTIFICATE OF DEATH

1000

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

BUREAU V. S.

MAY 16 1955

RECEIVED

INVESTIGATION

4697

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Harford</u>			
CITY OR TOWN <u>Harre-des-Grace</u>		LENGTH OF STAY (In this place) <u>3 WEEKS</u>		CITY OR TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>Watervale Road</u>					
3. NAME OF DECEASED (Type or Print) <u>James Parker Famous</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 11 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 22, 1873</u>	
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		13. FATHER'S NAME <u>Joseph Famous</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Rose Admoss, Fallston Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 Min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch Cardio-Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Unresolved lobar pneumonia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 19 1955</u> , to <u>May 11 1955</u> , that I last saw the deceased alive on <u>May 10 1955</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>		M. D. <u>Forest Hill Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>5/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) <u>Bel Air, Md</u>	
24. REC'D BY REGISTRAR <u>5-12-56</u>		REGISTRAR'S SIGNATURE <u>Russella Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foster Funeral Home</u>		ADDRESS <u>Bel Air, Md.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04703

4716

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Harford			
CITY OR TOWN (If outside corporate limits, write end give nearest town) X Abingdon		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (if rural give location) 1			
3. NAME OF DECEASED (First) (Middle) (Last) Marie L. Fenstermacher				4. DATE OF DEATH (Month) (Day) (Year) May 1 19 55			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH May, 21, 1909	9. AGE last birthday 45 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Richmond, Va.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 218-18-1825		17. INFORMANT & ADDRESS Daniel W. Fenstermacher, Abingdon, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Pulmonary edema						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerotic cardiovascular disease						6 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 10, 19 55, to May 1, 19 55, that I last saw the deceased alive on April 30, 19 55, and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
SIGNATURE Harold C Palmer				ADDRESS (Street, city, town, state) Bel Air Md.		DATE SIGNED 5/3/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May, 4, 1955		NAME OF CEMETERY OR CREMATORY Cokesbury		LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
24. REC'D BY REGISTRAR May 4, 1955		REGISTRAR'S SIGNATURE Norma G. Moore		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. Mc Comas & Son, Abingdon, Md.,			

CERTIFICATE OF DEATH

4112

Reg. Dist. No. 100

1. Usual Residence (Street or Highway)

2. Usual Residence (City or Town)

3. Date of Death

4. Time of Death

5. Place of Death

6. Cause of Death

7. Manner of Death

8. Signature of Physician

9. Signature of Registrar

10. Signature of Coroner

11. Signature of Medical Examiner

12. Signature of Health Officer

13. Signature of County Clerk

14. Signature of State Health Officer

15. Signature of Federal Health Officer

16. Signature of State Health Officer

17. Signature of Federal Health Officer

18. Signature of State Health Officer

19. Signature of Federal Health Officer

20. Signature of State Health Officer

21. Signature of Federal Health Officer

22. Signature of State Health Officer

23. Signature of Federal Health Officer

24. Signature of State Health Officer

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40. Signature of State Health Officer

41. Signature of Federal Health Officer

42. Signature of State Health Officer

43. Signature of Federal Health Officer

44. Signature of State Health Officer

45. Signature of Federal Health Officer

RECEIVED

BUREAU V. S.

MAY 6 1955

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04704

4717

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE MARYLAND		STATE Pennsylvania COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Aberdeen		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Stockertown		75 x 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital Aberdeen Proving Ground				STREET ADDRESS (If rural give location) 30 Weona Street		✓	
3. NAME OF DECEASED (First) LEWIS (Middle) (NONE) (Last) FLANK				4. DATE OF DEATH (Month) May (Day) 4 (Year) 19 55			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Oct 27, 1937	
9. AGE last birthday 17 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Bruce Flank		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes 29 Oct 54 to date	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Military Personnel Aberdeen Proving Ground, Md.		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Asphyxiation and charring of the body			
916.8 IMMEDIATE CAUSE (A)				30 minutes			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Barracks		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Aberdeen Proving Ground, Harford, Md.		21c. WHERE DID INJURY OCCUR? (City or town) 12 (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4 May 1955 at 7:00 A M.		21e. INJURY OCCURRED While at work Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Trapped in fire			
22. I hereby certify that I attended the deceased from 4 May, 19 55, to 4 May, 19 55, that I last saw the deceased alive on 4 May, 19 55, and that death occurred at 7:00AM from the causes and on the date stated above.							
SIGNATURE Richard Allen				ADDRESS (Street, city, town, state) M. D. U.S. Army Hosp., Aberdeen Proving Ground, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 5/5/55		NAME OF CEMETERY OR CREMATORY Nazareth Cemetery		LOCATION (City, town, or county) Nazareth, Penna	
24. REC'D BY REGISTRAR May 5-1955		REGISTRAR'S SIGNATURE Mellie R. Perry		25. FUNERAL DIRECTOR'S SIGNATURE John F. Farring Aberdeen Md.		ADDRESS	

250107070701

RECEIVED
BUREAU V. S.
1945

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF DEATH BALTIMORE, MARYLAND	
3. SEX Male		4. AGE 30	
5. DATE OF DEATH May 15, 1945		6. TIME OF DEATH 10:00 AM	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN J. H. HARRIS		10. SIGNATURE OF REGISTRAR J. H. HARRIS	
11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF DECEASED J. H. HARRIS	
13. SIGNATURE OF BURIAL OFFICIAL J. H. HARRIS		14. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
15. SIGNATURE OF CHURCH OFFICIAL J. H. HARRIS		16. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
17. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		18. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
19. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		20. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
21. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		22. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
23. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		24. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
25. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		26. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
27. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		28. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
29. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		30. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
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45. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		46. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
47. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		48. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
49. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		50. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
51. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		52. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
53. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		54. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
55. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		56. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
57. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		58. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
59. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		60. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
61. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		62. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
63. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		64. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
65. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		66. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
67. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		68. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
69. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		70. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
71. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		72. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
73. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		74. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
75. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		76. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
77. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		78. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
79. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		80. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
81. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		82. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
83. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		84. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
85. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		86. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
87. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		88. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
89. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		90. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
91. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		92. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
93. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		94. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
95. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		96. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
97. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		98. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
99. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		100. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04705

4718

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY OR TOWN <u>Harford</u> (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Harford</u> (If outside corporate limits, write RURAL and give nearest town) STREET ADDRESS <u>Rocky Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>MAUDIE ANN GOOD</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>MAY 6</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>3-12-1886</u>	9. AGE last birthday <u>69</u> Yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Labellia W. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Silas Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Manerva Crunkshank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Grant H. Good Rocky Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u>				15. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 mo. S yrs</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15, 1948</u> to <u>May 6, 1955</u> , that I last saw the deceased alive on <u>May 5, 1955</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles G. Hoff</u> M.D. ADDRESS <u>Street, Md.</u> DATE SIGNED <u>May 7, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>May 9</u>		NAME OF CEMETERY OR CREMATORY <u>Bell Air Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>Purcella Lowood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Montgomery & Ruth Janicki</u>			

CERTIFICATE OF DEATH

4718

Hartford

Jarrettville (Mary)

Mary Jarrettville
Hartford
Jarrettville

MAUDIE ANN GORD

MAY 6 22

Female White

Married 3-12-1886

88

1 12

House Wife

Local W. Va. and

2142 Morris

110

Hypertensive Cardiovascular Disease
Chronic congestive Heart Failure
Stroke in head
Married 3-12-1886
Local W. Va. and

None

BUREAU V. 31

April 25 May 6 22 12 1955

Charles D. Jeff

Bureau

Mary at birth then parents 1841

1966

Mary

Mary at birth then parents 1841

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4719

CERTIFICATE OF DEATH

04706

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>7 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Llewellyn @ Hall</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 14 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 10 - 1873</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles R Hall</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Prosser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Richard A Hall Forest Hill, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Peripheral Vascular Disease (Closure popliteal art. left leg with gangrene)</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						3 da.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chr. Cardio-vascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Emphysema</u>						?	
<u>Chr. Bronchial Asthma (Occasional attacks)</u>						?	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1936</u> , 19....., to <u>May 14</u> , 1955....., that I last saw the deceased alive on <u>May 14</u> , 1955....., and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson, M.D.</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>			
DATE SIGNED <u>5-15-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Center Methodist</u>		LOCATION (City, town, or county) <u>Forest Hill, Harford Co, Md</u>	
24. REC'D BY REGISTRAR <u>Priscilla Lowwood</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Laska Belair, Md.</u>		ADDRESS	
DATE <u>5-16-55</u>							

CERTIFICATE OF DEATH

6519

Rev. 1954

1. LOCAL NUMBER OF DEATH

DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illness

Drugs

Alcohol

Tobacco

Other

Signature

Witness

Physician

Coroner

Registrar

Other

Signature

Witness

Physician

Coroner

Registrar

Other

BUREAU V. S.

MAY 18 1955

RECEIVED

2 OCT 1954

RECEIVED

4698

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

Item 9, Film 182 6-8-55 et

1. PLACE OF DEATH COUNTY <i>Harford</i> STATE <i>Maryland</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harford</i>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harford</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old Bay Farm</i>				STREET ADDRESS (If rural give location) <i>Old Bay Farm</i>			
3. NAME OF DECEASED (Type or Print) (First) <i>James</i> (Middle) <i>Roy</i> (Last) <i>James</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>5/31/55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>6/1/1886</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Harry B. James</i>				14. MOTHER'S MAIDEN NAME <i>Ada McBone</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT & ADDRESS <i>Mary D. James, Old Bay Farm</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <i>Carcinoma, Sigmoid</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>General Carcinomatosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Cachexia</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>Jan 10 1955</i>				19b. MAJOR FINDINGS OF OPERATION <i>as above</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i>M.</i>				21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 1, 1955</i> to <i>May 31, 1955</i> , that I last saw the deceased alive on <i>May 31, 1955</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley</i>				DATE SIGNED <i>June 6/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>6/3/55</i>		NAME OF CEMETERY OR CREMATORY <i>Green</i>	
24. REC'D BY REGISTRAR <i>June 2-1955</i>				REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Harold Chan</i>	
DATE				ADDRESS (Street, city, town, state)		ADDRESS	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

CERTIFICATE OF DEATH

Form No. 100-100

1. Name of deceased (Print or write full name)

2. Sex (M or F)

3. Age (Years and months)

4. Date of birth (Month, day, year)

5. Place of birth (City, State, Country)

6. Race (Print or write)

7. Occupation (Print or write)

8. Cause of death (Print or write)

9. Date of death (Month, day, year)

10. Place of death (City, State, Country)

11. Signature of physician (Print or write)

12. Signature of registrar (Print or write)

13. Signature of informant (Print or write)

14. Signature of witness (Print or write)

15. Signature of funeral director (Print or write)

16. Signature of undertaker (Print or write)

17. Signature of cemetery (Print or write)

18. Signature of burial society (Print or write)

19. Signature of religious society (Print or write)

20. Signature of other (Print or write)

BUREAU V. 2.

JUN 3 1955

RECEIVED

4699

CERTIFICATE OF DEATH

04708

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>30 YRS</u>		CITY OR TOWN <u>HAVRE DE GRACE</u>		24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>336 OHIO ST</u>				STREET ADDRESS <u>336 OHIO ST</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY AGUSTA JOHNSON</u>				4. DATE OF DEATH <u>MAY 7 1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>BLACK</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>JULY 16, 1883</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BASSARD RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELSA PETERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT & ADDRESS <u>JOHN H. RICHARDSON</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Congestive Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive-Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1953</u> , to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>April 22, 1955</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury, M.D.</u>				ADDRESS (Street, city, town, state) <u>569 Revolution St. Havre de Grace, Md.</u>			
DATE <u>5-10-55</u>				DATE SIGNED <u>5/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JAMES</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, MD.</u>	
DATE <u>May 9 1955</u>							

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Conjunctive front failure

Hyper-tension - After a while, the heart dis-

BUREAU V. S.

MAY 10 1955

June 10 23 May 1

22 551-44

prol. ant. C. post.

Sept 12, 1895

4720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Md.		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Joppa, Md.		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Joppa		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 2, Mountain Road				STREET ADDRESS (If rural give location) Rt. 2, Mountain Road			
3. NAME OF DECEASED: (First) EDNA (Middle) A. (Last) KELSO				4. DATE (Month) (Day) (Year) OF DEATH: May 15 19 55			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Oct. 15, 1898	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Harry Holly				14. MOTHER'S MAIDEN NAME: Elizabeth Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: William Kelso, husband, above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CORONARY OCCLUSION						5 MINUTES	
ANTECEDENT CAUSE (B) CORONARY AND GENERALIZED						5 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. ARTERIOSCLEROSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES MELLITUS						5 YEARS	
19A. DATE OF OPERATION: 0 NONE		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/16 , 19 54 , to 5/15 , 19 55 , that I last saw the deceased alive on 5/14 , 19 55 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE E. W. Stewart, Jr.		ADDRESS BOX 95 EDGEWOOD MD.		DATE SIGNED 5/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 18, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		LOCATION (City, town, or county) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 5-18-55		REGISTRAR'S SIGNATURE A. W. Hedrick		24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

May 12, 1952
National Bureau of Investigation
Washington, D.C.

Harry Holly
at home
Baltimore, Md.
Elizabeth Holly
Wilmington, Delaware

married Oct. 15, 1937
at home
Baltimore, Md.

born
at S. Mountain Road
Baltimore, Md.

born
at S. Mountain Road
Baltimore, Md.

4721

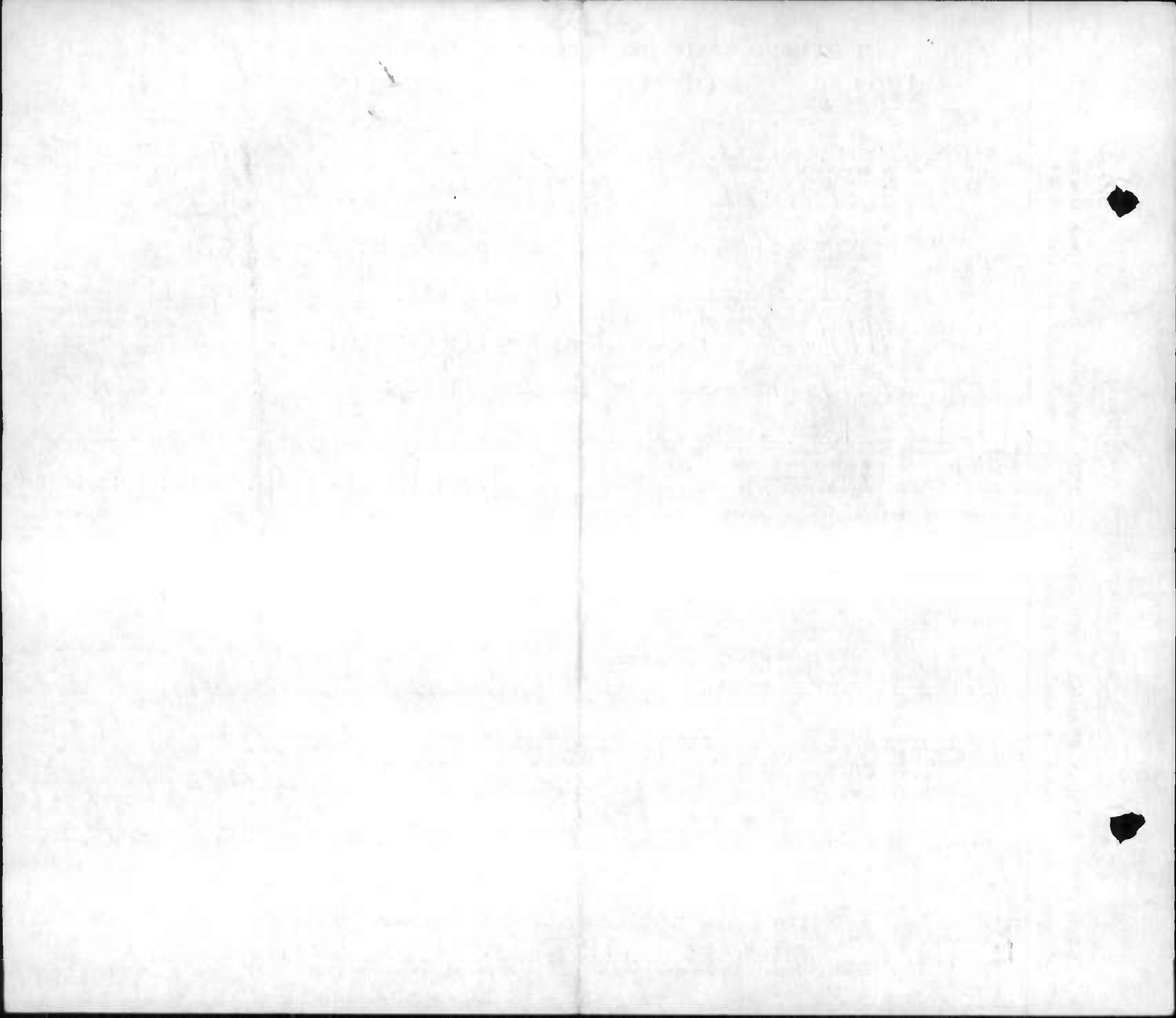
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harpord.</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Harpord</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>White Hall</u>	<u>33 yrs.</u>	TOWN <u>White Hall</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Green Rd.</u>		<u>Green Rd Norrisville</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Serge</u>	(Middle) <u>Levaskovich</u>	(Last) <u>Levaskovich</u>	(Month) <u>May</u> (Day) <u>11</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>June 27 1888</u>	
9. AGE last birthday: <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self</u>	
11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Philip Levaskovich</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unky.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Anna Posner Green Rd Norrisville</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>		<u>4 1/2 yrs</u>	
ANTECEDENT CAUSE (B) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>May 11, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Edward H. Hyson</u>		ADDRESS <u>Thorn Grove, Pa.</u> DATE SIGNED <u>May 11, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Doppel</u>		DATE THEREOF <u>May 14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-13-55</u>		REGISTRAR'S SIGNATURE <u>Dr. W. Hedgcock</u>	
FUNERAL DIRECTOR <u>Doppel Bros.</u>		ADDRESS <u>1800 E. Lombard St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04711
Reg. Dist.

No. 82

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY HARFORD		MARYLAND		STATE MD.		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN DUBLIN		60 YRS.		TOWN DUBLIN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH		5. (Month) (Day) (Year)	
RICHARD LAMAR McCANN				May 14		1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Sp. aff.)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	MARRIED	JAN. 2, 1895	60 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
MERCHANT		RETAIL		YORK CO., PA.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
BINGLEY McCANN				BERTHA FREY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
No				HAZEL G. McCANN, DUBLIN, MD.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
976X Immediate cause (a) Shot wound cerebrum DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Home		Dublin Harford Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
5/14/55 1P		M.		Shot self with pistol			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/14/55			
Dorald C Palmer				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
M. D.				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		5-16-55		DUBLIN		DUBLIN, MD.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-17-55		Prueella Lowwood		JOHN H. HARKINS, DELTA, PA.			

RECEIVED

MAY 18 1911

BUREAU V. 2

4700

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 04512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 186

1. PLACE OF DEATH:

COUNTY Harford MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN Harford LENGTH OF STAY (in this place) 7.07
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Harford
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR TOWN Chesapeake R. 717 #1
 STREET ADDRESS (If rural, give location) Stepney (near)

3. NAME OF DECEASED:

(First) Jesse (Middle) F. (Last) McConley
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
May 7 1955

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

June 7 - 1913

9. AGE last birthday: 41 yrs. 41 Months 0 Days 0 Hours 0 Min.
 IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Gun tester

10b. KIND OF BUSINESS OR INDUSTRY:

Army Govt.

11. BIRTHPLACE (State or foreign country):

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Frank M. Conley

14. MOTHER'S MAIDEN NAME:

Bertha Jovel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
 (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 231-01-9372

17. INFORMANT & ADDRESS:

Mrs Jesse F. McConley - Chesapeake

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
 Immediate cause

(a) Coronary occlusion
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
 (b) Coronary occlusion
 DUE TO
 (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☒ 5/7/55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

5/10/55

NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Gardens

LOCATION (City, town, or county)

Bel Air, Harford Co. Md.

DATE REC'D BY LOCAL REG.

May 9 - 1955

REGISTRAR'S SIGNATURE

G. L. Lewis M. D.

24. FUNERAL DIRECTOR

John G. Tarring Chesapeake Md.

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 10 1955

RECEIVED

4701

04713
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	CITY (If outside corporate limits, write OR and give nearest town)	STATE <i>Maryland</i>	CITY (If outside corporate limits write RURAL and give nearest town)
TOWN <i>Harford</i>	LENGTH OF STAY (in this place) <i>lifetime</i>	TOWN <i>Harford</i>	STREET ADDRESS (If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		634 Ontario	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Leveryng</i>	(Middle) <i>Joseph M.</i>	(Last) <i>Cullough</i>	(Month) <i>May</i> (Day) <i>17</i> (Year) <i>55</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>6/17/1919</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Cleaning</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Self</i>	9. AGE last birthday: <i>35</i> yrs. <i>11</i> Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.
11. BIRTHPLACE (State or foreign country): <i>Syracuse N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Edward L. M. Cullough Sr.</i>		14. MOTHER'S MAIDEN NAME: <i>Myrtle M. C. Key</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <i>U.S. S.</i>		16. SOCIAL SECURITY No.: <i>Unknown</i>	
17. INFORMANT & ADDRESS: <i>Magret P. M. Cullough 634 Ontario Rd Harford, Md.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Fracture skull</i>		
DUE TO		
Antecedent cause(s) (b) <i>977X</i>		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <i>5/17/55</i>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Harford Bridge</i>	21c. (City or town) (County) (State) <i>Harford Maryland Md</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>5/17/55 12:15 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Jumped off bridge</i>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Gerald C Palmer</i> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED <i>5/17/55</i>		
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>5/20/55</i>	NAME OF CEMETERY OR CREMATORY: <i>St. Louis</i>
LOCATION (City, town, or county) (State): <i>Harford, Md.</i>	24. FUNERAL DIRECTOR: <i>Wm. L. Lewis m.d.</i>	ADDRESS: <i>Harford, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04714

4723

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural --Darlington</u>		LENGTH OF STAY (in this place) <u>30 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-- Darlington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY</u> <u>ETHEL</u> <u>MONK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>15</u> , <u>1955</u>			
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>August 3, 1890</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Lebanon, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Mary Barker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Bascom Monk, Darlington, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Sudden</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chr. Hypertensive Cardio-vascular Disease</u>						<u>1 yr.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Chr. psycho-neurosis--psychogenic arthritis</u> <u>Minimal Pulmonary Tuberculosis--quiescent--</u>						<u>10 yrs.</u> <u>15 yr.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1935</u> , to <u>May 15, 1955</u> , that I last saw the deceased alive on <u>May 7, 1955</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>5-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain Cem</u>		LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u>	
24. REC'D BY REGISTRAR <u>May 16, 1955</u>		REGISTRAR'S SIGNATURE <u>C. A. Kirk</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. Usual Residence (House or Dwelling)

2. Date of Death
3. Time of Death
4. Place of Death
5. Cause of Death
6. Manner of Death
7. Name of Physician
8. Name of Hospital
9. Name of Nurse
10. Name of Undertaker
11. Name of Coroner
12. Name of Medical Examiner
13. Name of Pathologist
14. Name of Anatomist
15. Name of Embalmer
16. Name of Burial Place
17. Name of Cemetery
18. Name of Church
19. Name of Synagogue
20. Name of Mosque
21. Name of Other Place of Burial
22. Name of Other Place of Interment
23. Name of Other Place of Reburial
24. Name of Other Place of Disposition
25. Name of Other Place of Disposal
26. Name of Other Place of Disposal
27. Name of Other Place of Disposal
28. Name of Other Place of Disposal
29. Name of Other Place of Disposal
30. Name of Other Place of Disposal

3. Date of Death
4. Time of Death
5. Place of Death
6. Cause of Death
7. Manner of Death
8. Name of Physician
9. Name of Hospital
10. Name of Nurse
11. Name of Undertaker
12. Name of Coroner
13. Name of Medical Examiner
14. Name of Pathologist
15. Name of Anatomist
16. Name of Embalmer
17. Name of Burial Place
18. Name of Cemetery
19. Name of Church
20. Name of Synagogue
21. Name of Mosque
22. Name of Other Place of Burial
23. Name of Other Place of Interment
24. Name of Other Place of Reburial
25. Name of Other Place of Disposition
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100. Name of Other Place of Disposal

BUREAU V. 2

MAY 24 1955

RECEIVED

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4702

CERTIFICATE OF DEATH

04715

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>24 Harford Trace</u>		LENGTH OF STAY (in this place) <u>1 hr 38 Min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Harford Memorial Hospital</u>				STREET ADDRESS <u>RD #1</u>		(if rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Anthony</u> (Middle) <u>Phillip</u> (Last) <u>Myers</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5-2-55</u>	9. AGE last birthday <u>New Born</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ernest Myers</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Garettesti Kowalewski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ernest Myers, Aberdeen, R.D. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
761.5 IMMEDIATE CAUSE (A) <u>Premature Separation Placenta</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>5 1/2 month Pregnancy</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2</u> , 19 <u>55</u> , to <u>May 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city, town, state) <u>Howard K. McComas & Son, Md</u> DATE SIGNED <u>5/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>may 4-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> ADDRESS <u>Abingdon, Md.</u>			

2054386261

Howard K. McComas & Son

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4703

CERTIFICATE OF DEATH

04716

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>24 HAURE de GRACE</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>HAURE de GRACE 24</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD Memorial Hosp.</u>				STREET ADDRESS <u>561 FOUNTAIN</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>ELINOR</u> (First) <u>KAREN</u> (Middle) <u>Nelson</u> (Last)				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>30</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5-27-55</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wesley Graydon Nelson</u>				14. MOTHER'S MAIDEN NAME <u>NORMA JEAN BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>7625</u>				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>PULMONARY HYALINE MEMORANE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PREMATURITY -</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5-29-55</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-27-55</u>, 19<u>55</u>, to <u>5-30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>5-29</u>, 19<u>55</u>, and that death occurred at <u>4 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>AB Ornament M.D.</u>				DATE SIGNED <u>5-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>5-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		LOCATION (City, town, or county) <u>Haure de Grace Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. G. administrator</u>			

2055271382

CEPKA, YIPAA3

11-9-74

BUREAU V. S.

536 J. E. NODD

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4724

CERTIFICATE OF DEATH

04717

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Wilmington Rural 88 yrs</i>				TOWN <i>Wilmington Rural</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ida</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Ida Emma Orr</i>				<i>May 4 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR	
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Sept. 4 1866</i>		<i>88 yrs.</i>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>at home</i>		<i>Lancaster Co, Penna</i>		<i>U.S.A</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Isaac Eriest</i>				<i>Ruth Harris</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>No</i>		<i>Geon. Orr</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A)				<i>Cerebral Hemorrhage</i>		<i>suddenly</i>	
ANTECEDENT CAUSE(S) DUE TO				<i>Arterio Sclerosis</i>		<i>3 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)				<i>Myocarditis</i>		<i>3 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20a. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/20 1955</i>, to <i>5/4 1955</i>, that I last saw the deceased alive on <i>5/3 1955</i>, and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>F. E. Smyth</i>				ADDRESS (Street, city, town, state) <i>Wilmington, Harford Co. Md.</i>			
				DATE SIGNED <i>5/6/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 8, 1955</i>		<i>Wilmington</i>		<i>Harford Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>May 8</i>		<i>C. V. Fink</i>		<i>W. S. Bailey</i>		<i>Wilmington Md.</i>	

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Wilmington - Nov 20 1894

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BUREAU V. S.

MAY 10 1965

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May 2 C. H. Cook
May 8 1873 Mrs. C. H. Cook

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4704

CERTIFICATE OF DEATH

04718

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
32 TOWN <u>Bel Air</u>		10 yrs.		TOWN <u>Bel Air</u>		32	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>40 Hickory AVE</u>				140 Hickory AVE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Elizabeth K. Hardesty Richardson</u>				<u>May 26 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>JUNE 29, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Clay Hardesty</u>				<u>Mary Custus Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Dr. Lloyd Richardson, Bel Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						<u>ONE WEEK</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PRECIPITATED BY HERPES ZOSTER SEVERE</u>						<u>5 WEEKS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS</u>						<u>"ONE YEAR"</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 50</u> , to <u>26 MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26 MAY</u> , 19 <u>55</u> , and that death occurred at <u>11:42</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Bel Air</u>		DATE SIGNED <u>27 May 53</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>MAY 28, 1955</u>		<u>GREEN MOUNT CEMETERY</u>		<u>Baltimore</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-27-55</u>		<u>Priscilla Lowwood</u>		<u>Foster-Funeral Home</u>		<u>Bel Air, Md.</u>	

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INSTRUCTIONS

I

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4705

CERTIFICATE OF DEATH

04719

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>Harre de Grace Md.</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Aberdeen</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hospital</u>				STREET ADDRESS (If rural give location) <u>214 Schmechel St.</u>			
3. NAME OF DECEASED (Type or Print) <u>IDA L. ROBINSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 31 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>OCT 27 - 1888</u>	
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Theodore W. Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Culley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>husband Walter Robinson - same add.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
602X IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic pyelonephritis and renal calculi</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>—</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>May 3rd, 1955</u> to <u>May 31st, 1955</u> , that I last saw the deceased alive on <u>May 30th, 1955</u> and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A. ...</u>		DATE THEREOF <u>6/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Harmony chapel cemetery</u>		LOCATION (City, town, or county) (State) <u>Rowlandville, Cecil Co. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>G. L. Lewis m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. ...</u>		ADDRESS <u>Aberdeen Md.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4706

Item 9, Film 181 5-19-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04720

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 185

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Del.</u>		COUNTY <u>N. C.</u>	
CITY (If outside corporate limits, write RURAL OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Harre de Grace</u>		<u>D. O. C.</u>		TOWN <u>Wilmington</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Mem. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1115 West St</u>			
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Low</u>		(Last) <u>ROBINSON</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>2/19/34</u>	
9. AGE last birthday: <u>31</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Matron</u>		11. BIRTHPLACE (State or foreign country): <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Henry De Hoyos</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Pettoruto</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unde): <u>4</u>				16. SOCIAL SECURITY No.: <u>1115-211-21</u>		17. INFORMANT & ADDRESS: <u>Mrs Mary De Hoyos 1115 West St Wilmington, Del.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
819X Immediate cause (a) <u>F fracture skull</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>5/19/55</u>							
19b. MAJOR FINDING OF OPERATION:							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Wilmington</u>		21c. (City or town) (County) <u>Hartford</u>		(State) <u>Del.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/15/55 12:15 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident onto object type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lerald C Palmer</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/15/55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		LOCATION (City, town, or county) (State) <u>Wilmington Del.</u>	
DATE REC'D BY LOCAL REG. <u>May 15-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		24. FUNERAL DIRECTOR <u>Nicholas J. Corbato</u>		ADDRESS <u>Wilmington Del.</u>	

RECEIVED

MAY 17 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

04721

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
24 TOWN <u>Harre-de-Grace</u>	1 1/2 Hrs.	TOWN <u>Harre-de-Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
71 <u>Hartford Memorial Hospital</u>		<u>356 Congress Ave</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Charlotte</u> (Middle) <u>W</u> (Last) <u>SIPLEY</u>		(Month) <u>May</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>white</u>	<u>Single</u>	<u>JUNE 17 1900</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>54</u> yrs.	Months <u>5</u> Days <u>30</u>	Hours <u>30</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>School Teacher</u>	<u>Retired</u>	<u>New Jersey</u>	<u>U. S. A.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>George Siple</u>		<u>ELELYN WALTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>no</u>	
17. INFORMANT & ADDRESS			
<u>Margaret Harsh, sister</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
754.4 IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure - intermittent</u>		<u>18 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Congenital Heart Disease</u>		<u>life</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>May 18, 1952</u> to <u>May 18, 1955</u> that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
SIGNATURE <u>Frederick J. [Signature]</u> M.D. <u>177 N. Main Bld. Aberdeen Md.</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>CEDAR RIDGE</u>	
DATE THEREOF <u>5/21-1955</u>		LOCATION (City, town, or county) (State)	
		<u>WARREN CO. N. J.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		ADDRESS <u>RR Madison Mitchell, Harre-de-Grace, Md.</u>	
DATE <u>May 20-1955</u>			

1

CERTIFICATE OF DEATH

Reg. 1104, Md.

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MEDICAL EXAMINATION

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CLERK

23. SIGNATURE OF REGISTRAR

24. SIGNATURE OF JUDGE

BUREAU V. S.

MAY 23 1955

RECEIVED

2-21-1955 GEDARWIDE

EXHIBIT 10

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 23rd day of May, 1955, at 10:00 A.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 7 & 11, Film G183, 6/30/55 fcy

4725 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04722
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY _____	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Belcamp</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Cincinnati</u>		<u>72X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt # 40 (South lane)</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Cpl. James E. Taylor</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 15 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>21 August 1923</u>	9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Soldier Cpl. U.S. Army AP9nd</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Irvine, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>May Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>Current</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Military Personnel Office</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
(a) <u>916.5 Second degree burns entire body</u>							
Immediate cause DUE TO							
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO							
(c) stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Ante 40</u>		21c. (City or town) (County) (State) <u>Belcamp Harford 12 Met.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/15/55 1A</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Ante caught fire - (Parked Car)</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Donald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/15/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>5/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Balto National</u>		LOCATION (City, town, or county) <u>Cincinnati, Ohio Balto Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 17-1955</u>		REGISTRAR'S SIGNATURE <u>Hellie G. Perry</u>		24. FUNERAL DIRECTOR <u>John G. Tarring</u> ADDRESS <u>Cherchen Md.</u>			

RECEIVED

MAY 19 1955

BUREAU V. 1

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4708

CERTIFICATE OF DEATH

04723

Items 8,9: film G181 5-16-55 L; also Item 22.

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>Harford</u> <u>Maryland</u> CITY OR TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Harford</u> STREET ADDRESS <u>251 Alliance</u>	
3. NAME OF DECEASED (Type or Print) <u>Lillian</u> (First) <u>R.</u> (Middle) <u>Todd</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>	8. DATE OF BIRTH <u>10/6/1877</u> 1879 <u>44</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Russell Kahn</u>		14. MOTHER'S MAIDEN NAME <u>Emma Roll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Mr Homer Daugherty 251 Alliance Harford, Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 592X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertrophic Corrhoeis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Diffuse nephritis</u> SATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 22, 1955</u> , to <u>5-1-55</u> , that I last saw the deceased alive on <u>5-1-55</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>A. L. Lewis MD</u> M. D. <u>Harze de Grace MD</u>		DATE SIGNED <u>5-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>—</u>	
DATE <u>May 3-1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A18C 1-55 10M

CERTIFICATE OF DEATH

Spec. Form No. 10

1. Usual Residence (Street or Location)

2. Date of Death

3. Name of Deceased

4. Sex

5. Age

6. Race

7. Birth Date

8. Birth Place

9. Cause of Death

10. Place of Death

11. Signature of Physician

12. Signature of Registrar

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Health Officer

16. Signature of Burial Director

17. Signature of Undertaker

18. Signature of Funeral Home

19. Signature of Cemetery

20. Signature of Burial Society

21. Signature of Religious Society

22. Signature of Other

23. Signature of Other

24. Signature of Other

25. Signature of Other

26. Signature of Other

27. Signature of Other

28. Signature of Other

29. Signature of Other

30. Signature of Other

31. Signature of Other

32. Signature of Other

33. Signature of Other

34. Signature of Other

35. Signature of Other

36. Signature of Other

37. Signature of Other

38. Signature of Other

39. Signature of Other

40. Signature of Other

41. Signature of Other

42. Signature of Other

43. Signature of Other

44. Signature of Other

45. Signature of Other

46. Signature of Other

47. Signature of Other

48. Signature of Other

49. Signature of Other

50. Signature of Other

51. Signature of Other

52. Signature of Other

53. Signature of Other

54. Signature of Other

55. Signature of Other

56. Signature of Other

57. Signature of Other

58. Signature of Other

59. Signature of Other

60. Signature of Other

RECEIVED

MAY 5 1955

BUREAU V. S.

MAY 5 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4709

CERTIFICATE OF DEATH

04724

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
31 TOWN <i>Aberdeen</i>				31 TOWN <i>Aberdeen</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 29 Baker Street				1 STREET ADDRESS #29 Baker Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Rebecca</i> (Middle) <i>Jeannette</i> (Last) <i>Wagner</i>				(Month) <i>May</i> (Day) <i>29</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>June 20th 1874</i>	<i>80</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>Maryland</i>		<i>USA.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James B. Wake land</i>				<i>Susan Greenland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>				<i>*29 Baker St. Gus Wagner - Aberdeen Md.</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <i>Arterio Sclerotic Corda Vascular</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <i>Diabetes</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Cholesterol of Sides Arteries</i>							
(C) <i>Cachexia</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1, 1955</i> , to <i>May 29, 1955</i> , that I last saw the deceased alive on <i>May 29, 1955</i> , and that death occurred at <i>May 29, 1955</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Charles J. Foley</i>				DATE SIGNED <i>May 31/55</i>			
M.D.				ADDRESS (Street, city, town, state)			
				<i>Harford Md</i>			
23. BURIAL, CREMATION, REMOVA (SPECIFY)		DATE THERE OF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>June 1-1955</i>		<i>Churchoville Presbyterian Cemetery</i>		<i>Churchoville Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>June 1-55</i>		<i>Nellie R. Perry</i>		<i>John E. Garring</i>		<i>Aberdeen Md.</i>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04725

4710

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY OR TOWN <u>24 Harrede-Grace</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY OR TOWN <u>Rising Sun</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Hartford Memorial Hos.</u>				STREET ADDRESS <u>R. D # 2</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Calvin S. Watson</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 6, 1889</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.P.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>198-09-8811</u>		17. INFORMANT & ADDRESS <u>Mrs. Roland McMillen Perryville Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
521X IMMEDIATE CAUSE (A) <u>Brain abscess</u>						<u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary abscess</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 20</u> , 19 <u>55</u> , to <u>May 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Neil R. Taylor</u> M. D.				ADDRESS (Street, city, town, state) <u>Rising Sun Md.</u>		DATE SIGNED <u>5/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		LOCATION (City, town, or county) (State) <u>Near Post Deposit Md.</u>	
24. REC'D BY REGISTRAR <u>May 24-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Tyson</u>		ADDRESS <u>Rising Sun Md.</u>	

CERTIFICATE OF DEATH

4710

Reg. Date, etc.

1. Name of Deceased

MARYLAND

2. Place of Death

3. Date of Death

4. Time of Death

5. Cause of Death

6. Manner of Death

7. Age at Death

8. Sex

9. Race

10. Marital Status

11. Occupation

12. Education

13. Usual Residence

14. Date of Birth

15. Date of Admission to Hospital

16. Date of Discharge

17. Date of Death

18. Date of Death

19. Date of Death

20. Date of Death

21. Date of Death

22. Date of Death

23. Date of Death

24. Date of Death

25. Date of Death

26. Date of Death

27. Date of Death

28. Date of Death

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31. Date of Death

32. Date of Death

33. Date of Death

34. Date of Death

35. Date of Death

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37. Date of Death

38. Date of Death

39. Date of Death

40. Date of Death

41. Date of Death

42. Date of Death

43. Date of Death

44. Date of Death

45. Date of Death

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56. Date of Death

57. Date of Death

58. Date of Death

59. Date of Death

60. Date of Death

BUREAU V. S.

MAY 26 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

4726

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Fallston</u>		LENGTH OF STAY (in this place) <u>45 yrs</u>		CITY OR TOWN <u>Fallston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>—</u>			
3. NAME OF DECEASED (Type or Print) <u>Blanche B. Watson</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 6th 1882</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baldwin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Abraham Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Martha Streett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>James C. Watson Fallston, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				571.1 IMMEDIATE CAUSE (A) <u>Prob. Pulmonary Embolus</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Gastro Enteritis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				3 days			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12/27, 1950</u> , to <u>5/12, 1955</u> , that I last saw the deceased alive on <u>5/10, 1955</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. H. Barthel</u>				ADDRESS (Street, city, town, state) <u>Fallston Md</u>		DATE SIGNED <u>5/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 14 55</u>		NAME OF CEMETERY OR CREMATORY <u>Little Falls Friends</u>		LOCATION (City, town, or county) <u>Fallston Harford Md</u>	
24. REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martha Streett</u>		ADDRESS <u>—</u>	
DATE <u>5-14-55</u>							

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Received
 May 17 1955
 Bureau V. S.

RECEIVED
 MAY 17 1955
 BUREAU V. S.

James C. Watson Fallston Md
 Martha Street
 Baldwin Md
 Mary C. Watson Fallston Md
 May 15 1955

Fallston
 May 15 1955
 Fallston
 May 15 1955

CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12